Center For Cosmetic and Family Dentistry

Bill M. Lockhart D.D.S.

PATIENT INFORMATION

Patient's Name_____Social Security Number_____
Last First MI
Address_____
Street City Zip
Home Phone_____ Other_____
Sex □ M □ F Birth date_____/_____/_____ □ Single □ Married □Widowed □ Separated □ Divorced

Patient Employed By_____Occupation_____
Business Address_____Business
Phone_____
Business Email_____Personal Email_____
Whom May We Thank For Referring
You?_____
Notify in case of Emergency_____Home
Phone_____
Cell Phone_____Work Phone_____
Email_____

PRIMARY INSURANCE

Person Responsible for
Account_____
Last name First MI
Relation to Patient_____Birthdate_____Soc.
Sec.#_____
Address (If different) _____Home
Phone_____
City_____State_____Zip_____
Cell Phone_____Email_____
Person Responsible Employed
By_____Occupation_____
Business Address_____Business
Phone_____
Insurance
Company_____Phone_____
Contract #_____Group #_____Subscriber
#_____

ADDITIONAL INSURANCE

Is Patient Covered by Additional Insurance? □Yes □No
Subscriber Name_____Relation to
Patient_____Birthdate_____
Address (If Different from patient)
_____Soc.Sec.#_____
City_____State_____Zip_____Home
phone_____
Insurance
Company_____Phone_____
Contract #_____Group #_____Subscriber
#_____

DENTAL HISTORY

What Would You like us to do today?_____Are you in Dental Discomfort?_____
Former Dentist_____Address_____
Phone_____Date of Last Dental Care_____Date of last X-rays_____

Check (√) yes or no if you have had problems with any of the following:

□Y□N Bad Breath
□Y□N Bleeding Gums
□Y□N Clicking or popping jaw
□Y□N Food collection between teeth
□Y□N Grinding or Clenching teeth
□Y□N Loose teeth or broken fillings
□Y□N periodontal treatment
□Y□N Sensitivity to cold
□Y□N Sensitivity to hot
□Y□N Sensitivity to sweets
□Y□N Sensitivity when biting
□Y□N Sores or growths in mouth

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? □Y□N
Other Information about your dental health or previous treatment_____

MEDICAL HISTORY

Physician'sName_____Phone_____
Date of last visit_____Have you had any serious illness or operations □Y□N
If Yes, describe_____
Are you currently under physician care? □Y□N If yes, describe_____
Have you ever had a blood transfusion? □Y□N If yes, give approximate date_____
Have you ever taken Fen-Phen/Redux? □Y□N

Women: Are you pregnant □Y□N Nursing? □Y□N Taking Birth Control? □Y□N

Check (√) yes or no whether you have had any of the following:

□Y□N AIDS/HIV Positive
□Y□N Anaphylaxis
□Y□N Anemia
□Y□N Arthritis, Rheumatism
□Y□N Artificial heart valves
□Y□N Artificial Joints
□Y□N Asthma
□Y□N Atopic (Allergy Prone)
□Y□N Back Problems
□Y□N Blood Disease
□Y□N Cancer
□Y□N Chemotherapy
□Y□N Circulatory Problems
□Y□N Cortisone Treatments
□Y□N Cough, Persistent
□Y□N Cough up blood
□Y□N Diabetes
□Y□N Epilepsy
□Y□N Food Allergy
□Y□N Glaucoma
□Y□N Hemophilia/Abnormal bleeding
□Y□N Herpes
□Y□N Hepatitis
□Y□N High Blood Pressure
□Y□N Jaw Pain
□Y□N Kidney Disease/Malfunction
□Y□N Liver Disease
□Y□N Material Allergies(latex,wool,metal,chemicals)
□Y□N Mitral Valve Prolapse
□Y□N Nervous Problems
□Y□N Pace Maker/Heart Surgery
□Y□N Psychiatric Care
□Y□N Rapid weight gain/loss
□Y□N Radiation Treatment
□Y□N Respiratory Disease
□Y□N Rheumatic/Scarlet Fever
□Y□N Shingles
□Y□N Shortness of Breath
□Y□N Skin Rash
□Y□N Spina Bifida
□Y□N Tonsillitis
□Y□N Tuberculosis
□Y□N Ulcers/Colitis
□Y□N Venereal Disease

□Y□N Headaches
□Y□N Heart Murmur
□Y□N Heart Problems
describe_____
_____
□Y□N Stroke
□Y□N Surgical Implant
□Y□N Swelling of feet/ankles
□Y□N Thyroid Disease/Malfunction
□Y□N Tobacco Habit

Please list all medications patient is taking:

_____

_____

Please list all drug allergies:

_____

_____

I have reviewed all the above information on this form, and it is accurate to the best of my knowledge. I understand that this information will be solely used by the dentist to help determine appropriate and healthful dental treatment. If there are any changes in my medical status, I will inform the dentist as soon as possible. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I understand that insurance assignment is accepted for a period not to exceed forty-five days. After that time I the patient will be responsible for the balance.

Signature_____Date_____

Payment is due at time of treatment, unless prior arrangements have been approved.